STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 11933 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/14/10 through 9/16/10. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirements: F281, F314, F371, and F431.	F 000	Addendums noted with an asterisk per 10/21/10 telephone to facility administrator. SB/SDDOH/JJ	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26691 Based on observation, record review, interview, and policy review, the provider failed to ensure physician orders and care plans were followed and/or updated for two of thirteen sampled residents (1 and 13). Findings include: 1. Observation, interview, record review, and policy review revealed: *Resident 1's 3/30/10 physician orders for pressure ulcer treatment and prevention were not followed. *Necessary treatment and services were not administered for resident 1 to promote the healing of a stage 2 pressure ulcer. *The provider had not followed resident 1's care plan for the treatment of a stage 2 pressure ulcer. Refer to F314, finding 1. Surveyor: 28057 2. Observation on 9/15/10 at 4:00 p.m. revealed an open area on resident 13's coccyx. It was	F 281	Each resident with impaired skin integrity of a pressure ulcer is at risk for not having physician orders and care plans followed and/or updated. Primary physician was updated on condition of pressure ulcer and current tx for resident #13 on September 16, 2010. New orders were obtained and care planned. Compliance with new orders was verified with audit on October 8, 2010. Primary physician was updated on condition of pressure ulcer and current tx for resident #1 on September 20, 2010. New orders were obtained and care planned. Compliance with new orders was verified with audit on October 8, 2010.	11/5/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/25/10

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F 281	Continued From page 1 open to air with no dressing on it. Sensicare ointment was applied after the area was cleansed by the certified nursing assistant (CNA). Review of the quarterly Minimum Data Sets (MDS) dated 4/27/10 and 7/20/10 revealed: *The resident had one pressure ulcer. *It was a stage II ulcer. Review of the resident skin ulcer assessments revealed: *No open areas from 7/25/09 through 2/9/10. *Duoderm was applied to an open area on the coccyx on 2/9/10. *It was healed by 3/26/10. *The area on the resident's coccyx reopened on 4/17/10. *Was healed again by 8/14/10. *The area on the resident's coccyx reopened on 8/20/10 Review of the most recent physician orders dated 8/30/10 for resident 13 revealed a DuoDerm dressing was to be applied to the open area on the coccyx. It was to be changed every 3 days and per requested need (PRN). Review of the Physician Orders policy and procedure revised November 2009 revealed the physician orders must be reviewed every 60 days with the physician visit. The DuoDerm order had been in place since 2/9/10 without review or discontinuation of that order. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 419, revealed: "Nurses are obligated to follow physicians' orders unless they believe the orders are in error or	F 281	Each physician order for pressure ulcer treatment will be entered on physician order form, in the electronic medical record and on the care plan. The pressure ulcer treatment will be documented each time treatment is done. Physician will be contacted for any needs related to the pressure ulcer healing including, but not limited to, dressings and other treatments. Education for nursing staff was done at an in-service on October 6, 2010. Education included following Physicians Orders (1514) and updating physician per Skin Assessment Policy (J-7). State survey in-service education will be emailed by October 15, 2010 to PRN staff not in attendance at in-service. Follow up will be done with PRN staff at their next working shift. Monthly audits of residents with pressure ulcers will be completed by ADON or designee. Chart review of residents with pressure ulcers will be done to ensure that all pressure ulcer orders are reflected in the Electronic Medical Record and the care plan	

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F 281	Continued From page 2 would harm clients." Review of the 2/11/10 care plan for resident 13 revealed: *The resident had impaired skin integrity evidenced by an open area to the coccyx. *Interventions included Sensicare as needed and ensure DuoDerm was intact daily. Review of the care planning policy and procedure revised October 2003 revealed the care plan would be updated as needed by the nursing staff. Review of the 4/30/10 Resident Assessment Protocol (RAP) revealed: *Moisture cream was applied. *Occasionally would have a DuoDerm applied. Skin ulcer/Complex assessments completed on 5/28/10 and 9/10/10 revealed: *No dressing/open to air. *Sensicare #3 PRN. Interview with licensed pracitcal nurse (LPN) 9 on 9/16/10 at 8:55 a.m. revealed: *The DuoDerm was no longer used on the open area located on resident 13's coccyx. *It was no longer used because it bunched up and rolled causing more pressure to the area. *An order should have been obtained to discontinue the use of the DuoDerm. *It had "fell through the cracks" and should have been discontinued.	F 281	and that the resident is receiving the care that is ordered. In addition to the treatment compliance audit, the ADON or designee will audit each pressure ulcer documentation for proper physician notification. Audits will be reported quarterly to the QA committee by ADON until advised to discontinue reporting by the QA committee.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314	Each resident with impaired skin integrity of a pressure ulcer is at risk	11/5/10

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F 314	Continued From page 3 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 26691 Based on observation, record review, interview, and policy review, the provider failed to: *Follow the physician orders for one of one resident (1) with a pressure ulcer. *Ensure necessary treatment and services were administered to promote healing for one of two residents (1) with a pressure ulcer. *Ensure all necessary documentation was present for one of two residents (15) with a pressure ulcer. Findings include: 1. Review of resident 1's 3/18/10 hospital discharge summary and the physician's 3/30/10 admission orders revealed the primary diagnoses were persistent open sore of the left second digit of the left foot with cellulitis caused by pseudomonas (bacteria) organisms, renal insufficiency, hypertension, hypokalemia, arteriosclerotic heart disease, diverticulosis, degenerative joint disease, osteoporosis, and anemia. One basic treatment included the podiatrist (foot doctor) whenever necessary (PRN). Special information regarding care and treatment orders included: *Keep the left toe ulcer clean and dry with no shoe on the left foot. *Consult with the house podiatrist.	F 314	for not having physician orders followed and incorrect documentation and staging of pressure ulcers. Primary physician was updated on condition of pressure ulcer and current tx on resident #1 on September 20, 2010. New orders were obtained and care planned. Compliance with new orders verified with audit on October 8, 2010. Podiatrist appointment for resident #1 is scheduled for October 15, 2010. Resident #15 was a closed record review so no action is possible. Resident Care Supervisor or designee will monitor measurement and staging of all pressure ulcers with the weekly skin assessment report to assure they are being done correctly. Education on pressure ulcer measuring, staging, and documentation was done during nursing competency education on September 23, 27, and 29 of 2010.	

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F 314	Continued From page 4 *Use cast padding over the dorsal aspect to the left ankle under the ACE wraps. *ACE wraps from toes to high thigh. Review of resident 1's July 2010 and September 2010 signed physician orders revealed: *Podiatrist PRN. *Keep the left toe ulcer clean and dry with no shoes on the left foot. *Consult with the house podiatrist. *Use cast padding over the dorsal aspect to the left ankle under the ace wrap. *Ace wraps from the toes to high thigh in the morning and off at night. Review of resident 1's admission Minimum Data Set and Resident Assessment Protocol (RAP) summaries dated 4/4/10 revealed the resident had one stage 2 pressure ulcer and cellulitis of the left foot. The summary of findings for the triggered pressure ulcer RAP revealed: *A stage 2 pressure ulcer to the 2nd toe on her left foot. *ACE wraps on both legs and cast padding to the left leg under the ACE wrap. *Heel protectors and protective dressings. *Braden scale (assessment for risk of developing pressure ulcers) score of 16. *An in-house referral to see the in-house podiatrist PRN. The potential risks were delayed healing, infection, and further skin breakdown. The RAP for pressure ulcer would be care planned. Review of resident 1's admission care plan reviewed 6/21/10 revealed a potential for impaired skin integrity as evidenced by cellulitis to the left foot. Interventions included: *Preventative skin care.	F 314	Education was provided again at in-service for nursing staff done on October 6, 2010. State survey in-service education will be e-mailed by October 15, 2010 to PRN staff not in attendance at in-service. Follow up will be done with PRN staff at their next working shift. Monthly audits will be done by ADON or designee to assure measuring, staging, and documentation of all pressure ulcers is complete. See F281 for chart review audits. Audits will be reported quarterly to the QA committee by ADON until advised to discontinue reporting by the QA committee.	

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F 314	Continued From page 5 *Heel protectors or heel lift boots when in bed. *No shoe on the left foot. May wear slipper. *Prosource (nutritional supplement) in juice at breakfast. *Monitor skin daily with personal care (bathing, dressing, and personal hygiene). *ACE wraps on during the day and off at night. *May consult with the house podiatrist. *Skin ulcer complex assessment. Review of resident 1's 4/1/10 skin ulcer complex assessment revealed: *A stage 2 pressure ulcer on the left 2nd toe. *The length was 0.2 centimeters (cm) by 0.5 cm wide. *The wound was dry, crusted, 50-75% red granulated, with no drainage. *The surrounding tissue was pink. *The wound had no dressing and was left open to the air. Review of resident 1's 9/11/10 skin ulcer assessment revealed: *An ulcer on the left 2nd toe that was intact and crusted with no drainage or swelling. *The surrounding tissue was normal. *The wound measured 0.3 cm in length, 1.0 cm wide, and 0.1 cm deep. *A brown scab was present and the wound was improving slowly. Interview with resident care coordinator (RCC) 7 on 9/14/10 at 12:10 p.m. revealed: *Resident 1's wound was scabbed and healing slowly. *She thought the healing process had been complicated by the resident's admission diagnosis of cellulitis. *The nursing staff had not consulted with the	F 314		

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F 314	Continued From page 6 house podiatrist since resident 1 had been admitted on 3/31/10. *The podiatrist made "regular" rounds at the facility. *She did not know why the podiatrist had not seen resident 1 since her admission. *The nursing staff had not contacted resident 1's physician regarding the slow healing of the wound on the left 2nd toe, nor requested any new orders for treating the wound since resident 1's admission. *The nursing staff had not been using the cast padding on the left ankle under the ACE wrap as ordered by the physician on 3/30/10. The order for the cast padding had not been discontinued by the physician. *The provider no longer had a specific skin care nurse on staff. *They would consult with the hospital's wound care nurse as needed. 2. Observation on 9/16/10 at 1:30 p.m. of resident 1's left and right 2nd toes revealed: *The resident was wearing shoe-like slippers. *There was no cast padding to the left ankle under the ACE wrap as ordered by the physician. *The top of the left 2nd toe had a very small brown scab and a white flaked area where it appeared a scab had sloughed off. The surrounding tissue was red and soft-looking. *The toe itself was swollen at least two times the size of the right 2nd toe. Interview with registered nurse (RN) 8 at the time of the above observation confirmed the appearance of the ieft and right 2nd toes. Further interview with RN 8 and RCC 7 on 9/16/10 at 1:40 p.m. confirmed:	F 314		

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F 314	Continued From page 7 *There was no documentation in resident 1's record concerning a consultation with the house podiatrist since her admission. *There was no documentation the staff had requested any different treatment of the left 2nd toe from resident 1's physician. *Resident 1 had not taken any antibiotics since being discharged from the hospital on 3/18/10. Interview with the director of nursing on 9/16/10 at 2:05 p.m. revealed she would have expected the house podiatrist to have seen resident 1. He was at the facility "all the time doing rounds". Review of the provider's skin assessment policy revised January 2003 revealed: *All residents would be monitored for impaired skin integrity weekly and as needed. *Measures would be taken to predict residents at risk and to promote rapid healing. *If the pressure ulcer was not healing and/or signs of additional skin breakdown were evident alternative interventions would be considered every two weeks and attempted at least every 30 days. Surveyor: 12486 3. Review of resident 15's skin assessment notes from 6/13/10 to 7/24/10 revealed: *The resident had an open area to her left buttock since 6/13/10. *The skin was intact, dry and crusted, and no drainage was noted on the 6/13/10. *From 6/19/10 to 7/11/10 the weekly assessments listed the skin as being intact, dry, and no drainage. *On 7/17/10 the weekly assessment listed the skin as being open, red, and no drainage. *On 7/24/10 the weekly assessment listed the skin as being intact, dry, crusted, and no	F 314		

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F 314	Continued From page 8 drainage. *The pressure ulcer had not been staged on any of the weekly assessments. Review of the 7/13/10 quarterly Minimum Data Set revealed resident 15 had: *A stage II pressure ulcer. *Diagnoses of osteoporosis, Alzheimer disease, dementia, glaucoma, and allergies. Review of resident 15's care plan and interview with registered nurse (6) on 9/16/10 at 12:35 p.m. revealed: *The resident was not in failing health. *She received a protein supplement. *She had an air mattress on her bed, a gel cushion in her wheelchair, and was on a repositioning program. *The nurses had not been properly documenting the measurements of the pressure ulcers for residents with pressure ulcers. *During the Monday morning skin assessment report meetings it was discovered the documentation of pressure ulcers was not complete. *The appropriate measuring, staging, and documenting of pressure ulcers was being addressed during their nursing competency education the week of the survey and would be addressed again the following week. *The incomplete documentation had previously been discussed in numerous nursing meetings. *There was no system in place other than the Monday meetings to monitor or address the incomplete skin assessment documentation. Interview with the director of nursing on 9/16/10 at 2:15 p.m. confirmed the documentation of the open area with intact skin was confusing.	F 314		

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F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 11933 Based on observation, interview, and policy review, the provider failed to ensure food was stored, prepared, distributed, and served under sanitary conditions for three of three observed meals served to all residents with oral intake. Findings include: 1. Observation on 9/14/10 at 12:20 p.m. in the main kitchen/dining area of food prep associate (FPA) 3 revealed: *The noon meal was served from the steam cart positioned in the window section of the kitchen. *FPA 3 wore gloves. *She went from the tray line at the steam table to the kitchen area with the gloves on. *She returned to the tray line and continued to dish up the hamburger patties by grasping them with the same gloves she had on. *She picked up a handful of tator tots with the same gloved hand she had worn into the kitchen area and placed them on a plate. *She continued that process throughout the whole time the noon meal was being served.	F 371	By October 15, 2010 the Assistant Nutrition Food Service Director and Assistant DON will provide in-service training to all staff responsible for preparing and serving food to residents. The in-service will include education concerning appropriate glove use and hand hygiene. Utensils have been purchased and placed in operation to assist in the prevention of cross contamination of food. Weekly the Food and Nutrition Director or Assistant Food and Nutrition Director will observe the tray line and dining room staff for proper distribution and services of food under sanitary conditions. Results will be recorded on a checklist. The results of the tray line and dining room observations will be given to the Assistant DON. The Assistant DON will report the results to the Quality Assurance Committee at its [redacted] meetings until advised by the committee to discontinue reporting.	10/15/10 quarterly 5a/s0a0H/JJ

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F 371	Continued From page 10 *She did not change gloves or wash her hands at anytime throughout the meal tray preparation. 2. Observation on 9/15/10 at 11:30 a.m. in the main kitchen dining area of FPA 2 revealed: *The noon meal was being prepared by FPA 2 at the steam table, and food temperatures were being completed. *FPA 2 did not have gloves on, however he continued to push his eye glasses up on the nose, and touched his face and ear area. *He continued to touch the food dishes and the thermometer without washing his hands. *He left the steam table food preparation area and went to the kitchen area; he did not wash his hands when he returned. *He washed his hands after visible blood was noticed on his fingers, had to leave the handsink area to get paper towels, returned, and did not rewash his hands. *At 12:00 noon he placed food on the dinner plates, he touched his face and eye glasses, did not wash his hands afterward, and continued to put food on the dinner plates. 3. Observation on 9/15/10 at 11:55 a.m. in the main kitchen/dining area of FPA 3 revealed: *Pre-poured glasses of beverages were placed on a serving cart and wheeled to the dining area. *FPA 3 took hold of the beverage glasses by the top rim with her bare hands and placed the glasses on the dining tables. *That process continued throughout the whole time FPA 3 placed the glasses on the tables. *The handle of the serving cart was touched, tables were touched, and several residents were touched contaminating FPA 3's hands. She continued to pick up the beverage glasses by the top rim and had not washed her hands after she	F 371		

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F 371	Continued From page 11 had touched contaminated objects. *At no time during that process were her hands washed or alcohol cleanser used. Review of the provider's handwashing policy revised 9/16/10 revealed: *Hands must be washed between any contamination or after touching a contaminated surface. *Gloves must be worn when in direct contact with ready-to-eat food and changed when contaminated. *Gloves must be removed when contaminated, hands rewashed, and clean gloves reapplied. Interview on 9/16/10 at 10:00 a.m. with the nutrition food service director and the assistant food service director confirmed the FPAs should not have placed the hamburger patty and the tator tots on the dinner plates with their contaminated gloved hand. They further confirmed tongs or a spatula should have been used to serve the food. They confirmed the handwashing and gloving policies should have been followed. Surveyor: 26691 4. Observation on 9/14/10 from 12 noon until 12:30 p.m. in the main dining area of certified nurse assistant (CNA) 1 revealed she wore gloves. With those same gloves CNA 1: *Went to six different tables to assist residents with their hamburgers. *Touched residents' shoulders, hands, wheelchair handles, and silverware. *Picked up ketchup and mustard packets from the tables to put the condiments on the resident's hamburgers.	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 *Wiped her gloves on her apron two different times. *Picked up cheese slices, onions, the top half of the buns, and placed them on the residents' hamburgers. *Placed her left gloved hand on top of the buns while she cut the residents' cheeseburgers in half. At no time during the above observations did CNA 1 change her gloves or wash her hands. Interview with the nutrition food service director on 9/16/10 at 1:15 p.m. revealed CNA 1 was a new employee and needed more education in handwashing and glove use during the service of food. Surveyor: 28057 5. Observation on 9/14/10 at 12:08 p.m. in the main dining room revealed FPA 2 was serving plated food to a resident. He rubbed his nose with his hand and then continued to serve plated food to the residents without washing his hands.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	Medications were removed from the open spaces on all medication carts on September 16, 2010. Bins have been ordered to fill open spaces on all carts. Medication Administration Policy (M-1) revised to include the following: Medication that is not attended can not be left on top of the cart; nor can there be open bin areas in cart drawers where medications	11/5/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 26691 Based on observation and interview, the provider failed to safely store medications in three of four observed medication carts in three of four wings. Findings include: 1. Observation of the following medication carts from 9/14/10 at 5:20 p.m. through 9/15/10 at 10:40 a.m. revealed: *The A-wing, C-wing, and D-wing medication carts were missing several plastic drawers leaving open spaces where medications were stored. *Those medications were accessible to staff, visitors, and residents even when the medication carts were locked and licensed personnel were not present. *Those open spaces on the A-wing cart	F 431	could be stored. Education for nurses and medication aides on correct storage of medications was done at an in-service on October 6, 2010. Bi-monthly audits of medication carts will be done by ADON or designee for three months, then monthly to ensure proper storage of medications. Audits will be reported quarterly to the QA committee by ADON until advised to discontinue reporting by the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

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F 431	Continued From page 14	F 431		

contained:
-Nitrostat 0.4 milligram (mg) tablets.
-Nitroglycerin 0.4 mg patches.
*The accessible medications on the C-wing cart included:
-Tylenol 325 mg tablets.
-Benadryl 50 mg tablets.
-Meclizine 25 mg tablets.
-Humulin 70/30 insulin.
-Humalog insulin.
-Tramadol 50 mg tablets.
-Revatio 20 mg tablets.
-Lactinex OTC.
-Traclear 125 mg tablets.
-Darvon 100-650 mg tablets.
-Nitroglycerine 0.4 mg patches.
-Clotrimazole 10 mg tablets.
-Ondansetron tablets.
-Ex-Lax tablets.
-Simethicone 80 mg tablets.
-Miralax powder.
-Phenaseptic throat spray.
-Guaifenesin cough syrup.
-Drisdol 50,000 unit capsules.
-Clobetasol topical cream.
*The D-wing cart had one open space with:
-Nitroglycerine 0.4 mg patches.
-Chloraseptic throat lozenges.

Interview with LPN 10 on 9/15/10 at 10:40 a.m. confirmed the D-wing cart needed more drawers so the medications in the open spaces would not be accessible to residents, staff, and visitors.

Interview with LPN 11 on 9/15/10 at 10:50 a.m. confirmed the C-wing cart was missing drawers for the above accessible medications.

Interview with the director of nursing and RN 8 on

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	435042	A. BUILDING _____ B. WING _____	09/16/2010

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F 431	Continued From page 15 9/15/10 at 11:00 a.m. confirmed the A-wing, C-wing, and D-wing carts: *Had missing drawers and open spaces where medications had been stored making them accessible to residents, visitors, and staff when the carts were locked and unattended by licensed personnel. *Needed new drawers from the pharmacy to store those medications in. *Should not have medications stored in the open spaces without drawers.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 09/14/10. Avera Mother Joseph Manor Retirement Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 09/14/10 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column (X5) for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 012 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation and document review, the provider failed to meet the minimum construction standards of the 2000 Life Safety Code (LSC). The building construction type required a complete automatic sprinkler system. Findings	K 012		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tom Sye | Administrator | 10/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

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K 012	Continued From page 1 include: 1. Observation at 10:14 a.m. revealed the building was a two story structure with Type II (111) and Type IV (2HH) construction without a complete automatic sprinkler system. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 012		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation, measurement, and record review, the provider failed to maintain at least 32 inches of clear width for one set of randomly observed smoke barrier doors (between the 1961 original building and the 1980 addition) opening. Findings include: 1. Observation at 11:22 a.m. revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction.	K 028		F

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	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 028	Continued From page 2 The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation and record review, the provider failed to maintain at least two exits from the second level. Findings include: 1. Observation on 6/14/10 revealed the second level was not equipped with a conforming exit. The east and west stair enclosures discharged into the main level corridor system. Review of previous life safety code surveys confirmed those findings. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 032		F
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1	K 033		F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 033	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation and record review, the provider failed to maintain a one-hour fire-resistive path of egress from the second level to the exterior of the building. Two randomly observed stair enclosures discharged into the main level corridor system. Findings include: 1. Observation at 11:25 a.m. revealed the east and west second level stair enclosures discharged into the main level corridor system. A one-hour fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 033		
K 044 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain a 90 minute horizontal exit door in operating condition. One randomly observed 90 minute fire rated door between the original building and the assisted living center	K 044	The door between the original building and the assisted living facility was adjusted on September 17, 2010 so it closes properly. Face of door has been planed down to prevent hardware from rubbing when door swells. The door is on a preventative	11/05/10

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	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 044	Continued From page 4 addition did not function properly. Findings include: 1. Observation and testing at 12:56 p.m. on 9/14/10 revealed the west leaf of the double-doors between the original building and the assisted living center addition would not fully close and latch. That condition would not maintain the 90 minute fire resistive rating of that assembly. Interview with the maintenance director at the time of the observation revealed he had checked that door's operation during the last month's preventive maintenance checks he stated it had operated properly.	K 044	maintenance (pm) checklist for correct latching operation. The pm will be completed monthly by maintenance personnel. Results of the monthly preventative maintenance door latch check will be reported by the ADON to the QA committee quarterly until advised to discontinue reporting by the QA committee.	
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on observation and document review, the provider failed to meet the minimum construction standards of the 2000 Life Safety Code (LSC). The building construction type required a	K 056		F

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	435042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

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K 056	Continued From page 5 complete automatic sprinkler system. Findings include: 1. Observation at 10:14 a.m. revealed the building was a two story structure with Type II (111) and Type IV (2HH) construction without a complete automatic sprinkler system. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 056		

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	435042	A. BUILDING 2A - SOUTHWEST WING B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	1002 NORTH JAY STREET ABERDEEN, SD 57401

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/14/10. Avera Mother Joseph Manor Retirement Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27198 Based on testing, observation, and interview, the provider failed to ensure exits were readily accessible at all times. The south leaf of the east exit of building 2A would not open with a reasonable amount of force. The amount of force required would impede opening the door in an emergency situation. Findings include: 1. Testing at 11:46 a.m. revealed the south leaf of the east exit of building 2A would not be set into motion with a reasonable amount of force (not more then 30 lbf). Observation revealed that	K 038	The latching mechanism on the south leaf of the east exit door was adjusted on September 15, 2010 by House of Glass. Maintenance personnel will continue with monthly maintenance checklist for correct latching operation of door. The results of the monthly door latch check will be reported by the ADON to the QA committee quarterly until advised to discontinue reporting by the QA committee.	11/05/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 10/26/10

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	435042	A. BUILDING 2A - SOUTHWEST WING B. WING _____	09/14/2010

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K 038	Continued From page 1 exit doors latching mechanism was malfunctioning preventing it from being set into motion without a unreasonable amount of force (more then 30 lbf). Interview with the maintenance director at the time of the observation revealed he had checked that door's operation during the last month's preventive maintenance checks, and it had operated properly.	K 038		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 09/27/2010
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OMB NO. 0938-0391

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	435042	A. BUILDING 3A - NORTHWEST WING B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/05/09. Avera Mother Joseph Manor Retirement Community (Building 3) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 10/26/10

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PRINTED: 09/27/2010
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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10590	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/14/10 through 9/16/10. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirement: S156	S 000		
S 156	44:04:02:12 VENTILATION Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Rule is not met as evidenced by: Surveyor: 27198 Based on testing and interview, the provider failed to maintain exhaust fan ventilation in four randomly observed rooms (North wing [building A] soiled linen room, south wing [building B] soiled linen room, south wing [building B] clean linen room, and the C wing housekeeping room). Findings include: 1. Testing on 9/14/10 from 11:10 a.m. until 12:42 p.m. revealed the continuous mechanical exhaust fans were not operating in the North wing (building A) soiled linen room, south wing (building B) soiled linen room, south wing (building B) clean linen room, and the C wing housekeeping room. Testing of those exhaust vents did not show any negative pressure when	S 156	On September 28, 2010 Plant Operations staff replaced the motor on Building B exhaust fan. On September 28, 2010 Plant Operations staff replaced belt on Building A exhaust fan and C Wing Housekeeping room exhaust fan. Exhaust fans will be checked monthly by Plant Operations staff to ensure correct operation. If maintenance is required, it will be done at the time of the monthly inspection. Audits will be reported by ADON to QA committee quarterly until advised by QA committee to discontinue reporting.	11/05/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 10/26/10

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10590	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MOTHER JOSEPH MANOR RETI	1002 NORTH JAY STREET ABERDEEN, SD 57401

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S 156	Continued From Page 1 covered with a sheet of paper. Interview with the maintenance supervisor at the time of the testing confirmed those findings. He stated he was not aware the exhaust system was not functioning properly in those rooms. He stated they had just checked the exhaust fan units the day before, and they had been working,	S 156		